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An Early Look at Medicaid Managed Care in New Hampshire: Evaluation Findings from Year One

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Acknowledgements

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Endowment for Health

Today's Presentation Presents Highlights From:

"Risk-Based Managed Care in New Hampshire's Medicaid Program: A Qualitative Assessment of Implementation and Patient Experiences in Year One"

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Prepared for the Endowment for Health

To be released in the coming weeks

Medicaid Managed Care Implementation in New Hampshire

Step 1: Transition of state plan services for most beneficiaries

- Originally scheduled to begin July 2012
- Enrollment began September 2013 and coverage began December 1, 2013

Step 2: Transition of long-term services and supports and voluntary populations

- Enrollment for most Step 2 populations and services scheduled to begin in July 2015 and coverage in September
- Several waiver populations will be phased in later

Step 3: ACA Medicaid expansion population

- Coverage under Medicaid managed care began in August 2014 for those without cost-effective access to employer coverage
- Pending waiver approval this population will be transferred to the health insurance marketplace in 2016

Evaluation Overview

Three year evaluation beginning January 2014

Qualitative Component (Years 1-3)

- Understand and document the implementation process
- Identify transition experiences in terms of health care continuity, quality, and utilization

Quantitative Component (Years 2-3)

- Assess impacts on access, service use, quality and costs

Qualitative Methods

Key informant interviews conducted in two regions in July 2014

- Manchester/ Concord (Urban Area)
- "North Country" (Rural Area with Longstanding Provider Shortages)

Document Review

- Managed care contracts
- Newspaper articles
- Quality Strategy and Key Indicator Reports
- EQRO focus group report
- Materials presented to the Governor's Commission on MCM

Focus Groups

Interview and Focus Group Details

Interview Type	No. of Interviewees
State Official or Partner	5
Health Plan	2
Provider or Provider Association (Acute Care)	8
Provider or Provider Association (LTSS)	3
Mental Health Provider or Advocate	2
LTSS Advocate	3
FG Type	**No. of Participants**
Parents of Healthy Children	7
Using Mental Health System	6
Long-Term Services and Supports	3

Interview Protocol Topics

Topic	State	Health Plan	Advocate	Provider
State Oversight	X			
Plan Selection	X			
Credentialing		X		X
Contracting				X
Prior Authorization				X
Coding and Billing				X
Denials and Appeals				X
Education and Enrollment	X	X	X	X
Provider Networks	X	X	X	X
Continuity of Care	X	X	X	X
Quality and Access	X	X	X	X
Case Management	X	X	X	X

Focus Group Methods

Three groups were recruited in one region

A recruitment plan was developed for each focus group to minimize selection bias

- Parents of children enrolled in Medicaid managed care (n=7)
- Adults utilizing behavioral health services (n=6)
- Caretakers of those accessing long-term services and supports (n=3)

Thematic Content Analysis

Identify patterns across data sets to describe phenomenon

Steps:

- Formulate research questions
- Develop interview protocols and collect data
- Transcribe notes
- Review notes, develops preliminary code set based on themes that emerge
- Code notes and revised code list

Data was not considered a theme if it did not emerge from multiple informants and/or multiple information types

Selected themes are presented as conclusions

Summary of Findings from Year One (1)

Initial implementation of managed care in New Hampshire's Medicaid program went relatively smoothly along several dimensions:

- Providers and patients had ample education about the transition
- State took on a strong oversight role
- Major stakeholders were in constant communication
- Access to providers appears not to have been hindered to this point

Summary of Findings from Year One (2)

But, there is potential for improvement in some key areas as managed care evolves in Medicaid

- Providers and patients reported significant problems related to prior authorization processes, particularly with regard to pharmacy services
- Case management programs are still developing

A great deal of uncertainty exists with regard to the implementation of Step 2

Findings: Education & Enrollment

The process of educating patients about the transition to risk-based managed care was seemingly successful

- As compared to other states, NH seems to have had a high number of beneficiaries self-selecting their plans
- Selection criteria included: provider networks and "extras" offered by plans

Those who didn't self-select were auto-assigned

Findings: State Oversight

State sees transition as an opportunity for a new level of oversight

State did extensive outreach with providers and enrollees

State is working with plans to develop quality infrastructure

- Allows for more population-level management of Medicaid enrollees
- Ambitious quality strategy developed by DHHS
- Monthly Key Indicator reports beginning in August 2014
- Strong state oversight of health plan quality

Findings: Provider Experience

Few issues were reported related to contracting or credentialing with plans

Providers did not express a lot of concern related to claims submission and payment

A few payment issues did surface

- Information Gaps
- Unique Billing and Coding Arrangements
- Denials

Provider representatives at the health plans were reportedly not particularly helpful

Findings: Prior Authorization

- Providers noted that the single biggest issue they faced with regard to managed care was prior authorization
  - Prior authorization could delay patient care
  - Prior authorization requirements were also thought to be administratively burdensome.
- Patients also experienced problems with prior authorization
  - Delays in receiving drugs
  - Problems with prior authorization for transportation
  - In some cases, did not account for patient history
- State is aware of provider issues and has expressed a desire to ease administrative burdens

Findings: Case Management

Case management programs were developed by both plans, but they were small and seemingly not fully developed

Both plans seemed to be focused on pregnant women at the time of the interviews in the summer of 2014

Findings: Patient experience based on focus group findings

Ability to Get Appointments

- Patients noted few problems accessing the primary, specialty and emergency room care that they needed
- Provider networks did not seem to suffer

Transportation

Translation

- Two focus group participants noted this as a problem for the Nepalese community

Implications for Step 2

Providers report concerns about prior authorization requirements as they pertain to LTSS

Some were concerned that disabled populations will not have the information they need to make an informed health plan choice

Looking Ahead

Areas to Monitor

- Prior authorization requirements and administrative burdens
  - Adequacy of provider networks
- Development of case management programs and changes in patterns of patient care
- Consistency of pre- and post-managed care data
- Cost savings

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Questions?

Contact APalmer@urban.org